Occupational Therapy Discharge Report

Lock

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment

DATE(S) OF ASSESSMENT			
(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)

DATE(S) OF TREATMENT SINCE LAST REPORT
(dd/mmm/yyyy)

TOTAL NUMBER OF CLIENT VISITS	
OT VISITS	RA/KIN VISITS

Medical And Rehabilitation Information

1. CURRENT MEDICAL STATUS/UPDATE:

Subjective Assessment — Client Interview

2. ONGOING SYMPTOMS/CONCERNS:

Objective Assessment

3. ONGOING SYMPTOM PRESENTATION

○ Yes ○ No

IF YES, SELECT AT LEAST ONE ONGOING SYMPTOM PRESENTATION:

☐ Pain ☐ Headaches ☐ Noise/light sensitivity ☐ Fatigue/sleep disturbance
☐ Dizziness ☐ Nausea ☐ Paresthesia/altered sensation ☐ Other :_____

4. UPDATED INFORMATION:

PERFORMANCE COMPONENT

5. PHYSICAL LIMITATIONS

○ Yes ○ No

If 'No' on Question 5, skip to Question 11

6. SELECT AT LEAST ONE PHYSICAL LIMITATION:

☐ ROM ☐ Strength ☐ Balance ☐ Coordination ☐ Other :_____

7. PROVIDE UPDATED INFORMATION ABOUT PHYSICAL LIMITATIONS:

8. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

If 'No' on Question 8, skip to Question 11

9. IF YES, SELECT AT LEAST ONE:

☐ Lifting/Carrying ☐ Pushing/pulling ☐ Reaching ☐ Hand function ☐ Postural tolerances ☐ Standing
☐ Sitting ☐ Stooping ☐ Sustained neck flexion

10. PROVIDE UPDATED INFORMATION ABOUT LIMITATIONS AFFECTING FUNCTIONAL ABILITY:

11. COGNITIVE LIMITATIONS

○ Yes ○ No

If 'No' on Question 11, skip to Question 14

12. SELECT AT LEAST ONE COGNITIVE LIMITATION:

☐ Attention ☐ Initiation ☐ Visual scanning/perception ☐ Awareness ☐ Executive function ☐ Other :_____

13. PROVIDE UPDATED INFORMATION ABOUT COGNITIVE LIMITATIONS:

14. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

If 'No' on Question 14, skip to Question 17

15. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

☐ Multi-tasking ☐ Planning/organization ☐ Problem-solving/decision-making
☐ Frustration tolerance ☐ Communication skills ☐ Safety/judgment

16. PROVIDE UPDATED INFORMATION ABOUT LIMITATIONS AFFECTING FUNCTIONAL ABILITY:

17. PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS

○ Yes ○ No

If 'No' on Question 17, skip to Question 21

18. SELECT AT LEAST ONE PSYCHOSOCIAL/BEHAVIOURAL LIMITATION

☐ Anxiety ☐ Mood ☐ Frustration tolerance ☐ Social avoidance/isolation ☐ Other :_____

19. PROVIDE UPDATED INFORMATION ABOUT PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS:

20. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

IF YES, PROVIDE UPDATED INFORMATION:

FUNCTIONAL STATUS

ADL

21. MOBILITY/TRANSFERS: IS CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:	IF NO, PROVIDE UPDATED INFORMATION:
☐ Requires extra time/equipment ☐ Requires assistance	

22. SELF-CARE: IS CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:	IF NO, PROVIDE UPDATED INFORMATION:
☐ Requires extra time/equipment ☐ Requires assistance	

IADL

23. HOUSEHOLD MANAGEMENT: IS THE CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:	IF NO, PROVIDE COMMENTS:
☐ Requires extra time/equipment ☐ Requires assistance	

TRANSPORTATION

24. PRE-ACCIDENT:

25. CURRENT:

Work Status

26. IS THE CLIENT STILL JOB ATTACHED?

○ Yes ○ No

27. IS THE CLIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)

☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

28. HAS THE CLIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?

Work: ○ Yes ○ No Training: ○ Yes ○ No School/Studies: ○ Yes ○ No

If the client is continuing to work, study or train indicate their status, as applicable

29. STATUS OF DUTIES

Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

30. STATUS OF HOURS

Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

31. CRITICAL JOB DEMAND 1

ABLE TO MEET ○ Yes ○ No

CRITICAL JOB DEMAND 2	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 3	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 4	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 5	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 6	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 7	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 8	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 9	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 10	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 11	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 12	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 13	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 14	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 15	ABLE TO MEET ○ Yes ○ No

32. IS RETURN TO WORK A GOAL OF REHABILITATION AT THIS TIME?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

33. IS EMPLOYER ABLE TO ACCOMMODATE GRADUAL RETURN TO WORK?

○ Yes ○ No ○ To be determined

Summary/Analysis

34. SUMMARY/ANALYSIS:

Recommendations

RETURN TO FUNCTION RECOMMENDATIONS (equipment, services, rehabilitation, other)
RECOMMENDATIONS

RETURN TO WORK RECOMMENDATIONS (equipment, services, rehabilitation, other) Fill this section if the client is NOT working or working modified duties/hours.
RECOMMENDATIONS

Report Distribution

REPORT DISTRIBUTED TO THE FOLLOWING TEAM MEMBERS	
☐ Family physician	
☐ Specialist	
☐ PT	
☐ Lawyer	
☐ Other	

Service Provider Information

CONTACT PREFERENCE	
☐ By phone	CONTACT PHONE NUMBER
☐ By email	CONTACT EMAIL

Additional Comments/Information

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

☐ I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and Section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.